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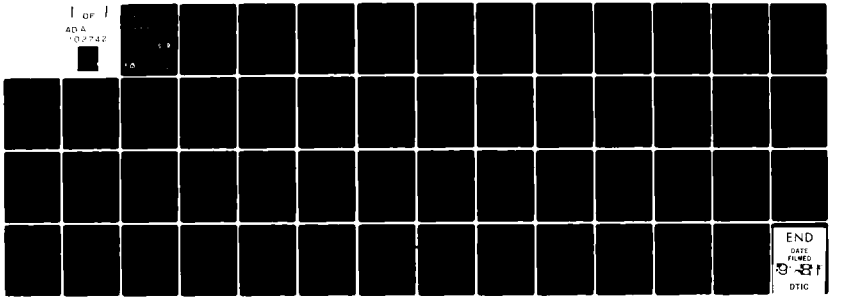

STUDY BY THE STAFF OF THE U.S.

General Accounting Office.

Impediments To State Cost Saving Initiatives Under Medicaid.

This study discusses instances over the past 7 or 8 years in which State attempts to reduce or terminate benefits or restrict eligibility under their Medicaid programs have been delayed or blocked in the Federal courts as being inconsistent with Federal law and/or regulations.

In view of the administration's proposal to "cap" Federal financial participation in the State-operated Medicaid programs and to give the States more flexibility, this study identifies the kinds of Federal requirements that most often have been the subject of litigation.

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PREFACE

This study was undertaken at the request of the Chairman, Senate Committee on Finance, in connection with the administration's proposal to limit or "cap" Federal financial participation in the State-operated Medicaid programs and to modify Federal requirements to give the States more flexibility in managing their programs and thus to contain their costs.

Concerning possible modifications to Federal requirements, this study identifies instances over the past 7 or 8 years in which States have attempted to introduce cost saving initiatives to their programs, focusing on instances in which such efforts have been challenged or blocked in the Federal courts as being inconsistent with Federal law and/or regulations.

The study consists of four parts:

--The first (ch. 2) discusses State efforts to reduce or terminate benefits.

--The second (ch. 3) discusses court cases involving the implementation of the cost-based reimbursement requirements for hospitals and nursing homes contained in the Social Security Amendments of 1972 (Public Law 92-603).

--The third (ch. 4) discusses challenges in the Federal courts to State rules pertaining to Medicaid eligibility.

--The fourth (ch. 5) discusses selected State initiatives in containing costs through waivers of Federal Medicaid requirements and Arizona's policies in providing health care to the poor. Arizona is the only State that does not participate in the Medicaid program and thus is not subject to the Federal Medicaid requirements.

This study should be useful to the Congress as it considers the possible ramifications of the proposed Medicaid "cap" and the extent that existing requirements should or could be modified to give States more flexibility.

We received oral comments on a draft of this study from representatives of the Department of Health and Human Services' Office of General Counsel and have incorporated the information furnished as appropriate in the study.

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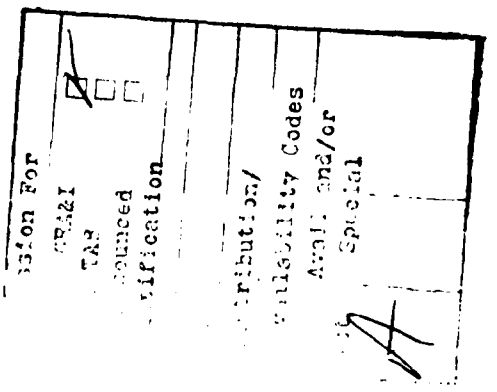

ABBREVIATIONS

AFDC	Aid to Families with Dependent Children
CCH	Commerce Clearing House, Inc.
HCFA	Health Care Financing Administration
HHC	Health and Hospital Corporation
HHS	Department of Health and Human Services
ICF	intermediate care facility
MCAC	Medical Care Advisory Committee
SNF	skilled nursing facility
SSI	Supplemental Security Income

CHAPTER 1

INTRODUCTION

In February 1981, the President submitted to the Congress budget proposals as part of the administration's Economic Recovery Plan. Included in these budget proposals was the "capping" of Federal contributions to the $28 billion State-operated Medicaid programs to pay for the health care of the poor. Coupled with this proposal, Federal law would be modified to give the States more flexibility in managing their programs.

On March 10, 1981, the Secretary of Health and Human Services presented to the Congress the Department's fiscal year 1982 revised budget, which also featured the capping of Federal Medicaid expenditures in 1981. The limit would be structured to reduce Federal expenditures by $100 million below then current estimates for that year. Federal expenditures would be allowed to increase by 5 percent in 1982, which would make Federal expenditures about $1 billion less than the expected expenditures under the existing open-ended program.

According to the revised budget proposal, total Federal expenditures for Medicaid for the 3-year period 1980-82 under the current and proposed program would be as follows:

Year	Current	Proposed
	(billions)	
1980	$14.0	$14.0
1981	16.5	a/16.1
1982	18.2	17.2

a/Includes other reductions to reflect a proposed change in the methods of collecting disallowed Medicaid expenditures from the States.

The Department of Health and Human Services' (HHS') proposal also stated that legislation would be proposed giving States additional flexibility to target services to the truly needy and to develop innovative methods for financing and delivering services. On May 15, 1981, HHS presented the details of its proposal to the Congress in the form of a draft bill to be entitled the "Health Care Financing Amendments of 1981."

THE MEDICAID PROGRAM

Medicaid is a Federal/State program under which the Federal Government pays from 50 to 78 percent of State costs of providing health services to the poor. Medicaid was authorized by title XIX

of the Social Security Act, which was established by the Social Security Amendments of 1965 (Public Law 89-87) and became effective on January 1, 1966. Medicaid consolidated and expanded the medical assistance provisions of the cash assistance programs for the aged, blind, disabled, and families with dependent children. Except for Arizona, all States, as well as the District of Columbia, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands, have elected to participate in Medicaid.

The States are responsible for designing, establishing, and operating their Medicaid programs under the provisions of title XIX and HHS regulations. The law requires the States with Medicaid programs to provide inpatient and outpatient hospital services; laboratory and X-ray services; physician services; family planning services; and early and periodic screening, diagnosis, and treatment services for eligible persons under 21 years of age. HHS regulations require the States to provide transportation to and from medical providers. Title XIX also permits the States' Medicaid programs to cover any other medical or remedial services recognized under State law.

Medicaid can cover two groups of persons. The first group is the "categorically needy," which include individuals who receive, or are eligible to receive but have not applied for, cash assistance under either the Supplemental Security Income (SSI) program or the Aid to Families with Dependent Children (AFDC) program. The categorically needy must be covered under Medicaid, except that a State can choose to use more restrictive eligibility criteria for aged, blind, and disabled persons than SSI's criteria which became effective in January 1974. However, the criteria cannot be more restrictive than the criteria used by the State in 1972.

The second group is the "medically needy," which include persons whose income and/or resources are too high to receive cash assistance but are too low to pay for their medical care. As of June 1979, 34 States and jurisdictions had elected to cover the medically needy.

State Medicaid plans list the eligibility criteria for Medicaid; the amount, duration, and scope of services covered; and the methods the State will use to administer the program. HHS' Health Care Financing Administration (HCFA) approves, for Federal cost sharing, State plans that meet Federal requirements. HCFA also monitors State Medicaid operations to ensure that they conform to Federal requirements and the approved State plan.

During the last decade Federal and State Medicaid costs have steadily increased from about $6 billion in 1970 (when all but two States had programs) to an estimated $28 billion in 1981.

WHO RECEIVES MEDICAID BENEFITS?

From 1974, when program costs were about $11 billion, to 1981, the total number of people receiving Medicaid benefits has not significantly increased. As shown by the following table, except for an upward surge of recipients in 1976, the number of people receiving benefits has generally ranged between 22 million and 23 million with the numbers of blind and disabled receiving Medicaid assistance showing a slight increasing trend and the number of aged showing an offsetting slight decrease.

Unduplicated Count
of Medicaid Recipients
by Eligibility Category

Year	Total	Aged	Blind and disabled	AFDC and other
	(thousands)			
1974	22,009	3,805	2,416	15,788
1975	22,413	3,699	2,415	16,299
1976	24,666	3,808	2,762	18,096
1977	23,833	3,619	2,826	17,388
1978	22,946	3,786	2,979	16,181
1979	22,894	3,690	3,157	16,047
a/1980	21,735	3,400	2,852	15,483
a/1981	22,513	3,482	2,942	16,089

a/Estimates from HHS' 1982 Revised Budget Summary.

WHO GETS THE MONEY?

Based on 1978 data, the $18 billion in vendor payments in that year were paid to providers as follows:

Type of service	Percent of total payments
Inpatient hospital	27.7
Hospital and institutional services for the mentally ill or retarded	10.3
Nursing homes (note a)	35.0
Physician services	8.8
Dental and other practitioners	2.6
Outpatient hospital	4.5
Prescribed drugs	6.0
Other (note b)	5.1
Total	100.0

a/Includes skilled nursing facilities and intermediate care facilities.

b/Consists principally of clinical services, laboratory and radiological services, home health, and family planning.

Thus, over 75 percent of the Medicaid money goes to institutional providers, such as hospitals and nursing homes.

OTHER STUDIES PROVIDING INSIGHTS INTO STATE PREFERENCES FOR FLEXIBILITY OR COST SAVING INITIATIVES

We have identified at least three other studies that give some insights into which Federal requirements the States believed should be removed or modified as well as into States' initiatives to contain Medicaid costs.

A study by the American Public Welfare Association under a HCFA grant 1/ has produced preliminary findings indicating that the States perceive the following five Federal requirements and related statutes and Federal regulations as the most significant barriers to effective administration.

--Medicaid recipients' freedom of choice of providers (section 1902(a)(23); 42 CFR 431.51). Section 102(g) of the HHS May 15, 1981, proposed bill would replace this with a requirement to provide such standards as could reasonably be expected to afford recipients covered medical care of adequate quality.

1/"Federal Regulations, Reporting Requirements and Statutes as Barriers to Efficient Medicaid Program Operation: The State Perspective" (Grant No. 18-P-97959 3-01).

--Reimbursement of the reasonable costs of inpatient hospital services (section 1902(a)(13)(D); 42 CFR 447.261). Section 102(d)(3) of the HHS proposed bill would repeal this.

--States cannot limit services based on diagnosis, illness, or condition and must make services equal in amount, duration, and scope to all recipients in the same category (sections 1902(a)(10) and 1902(a)(13)(B) and (C) and 42 CFR 440.230-440.250). Sections 102(c) and (d) of the HHS proposed bill would eliminate these requirements with respect to the medically needy but would still require certain mandatory services for the categorically needy.

--Requirements and penalties related to the Early and Periodic Screening, Diagnosis, and Treatment program (sections 1905(a)(4)(B) and 403(g); 42 CFR 441 subpart B). The HHS proposed bill would repeal the penalty provision of section 403(g), including the requirement that all families be informed of the availability of screening services.

--Nursing home reimbursement on a reasonable cost-related basis (section 1902(a)(13)(E) and 42 CFR 447.272-316). 1/ Section 102(d)(3) of the HHS proposed bill would repeal this.

Another study is an inventory of recent or proposed changes in State Medicaid programs by the Intergovernmental Health Policy Project of George Washington University in Washington, D.C. The inventory included such changes as increasing copayments on prescription drugs and other optional services; making exclusive contracts for the purchase of drugs, laboratory services, and durable medical equipment; limiting perceived recipient abusers to one doctor and one pharmacy; establishing or reducing limits on the number of hospital days; and imposing restrictions on eligibility.

Another project by the National Governors' Association under a HCFA grant developed a "State Guide to Medicaid Cost Containment," 2/ which set forth cost-containment strategies involving

--minimizing or eliminating the use of open-ended and/or provider-controlled reimbursement for nursing homes, hospitals, and physicians;

--minimizing provider and recipient misuse of the program;

1/This section was modified by section 961 of Public Law 96-499, the Omnibus Reconciliation Act of 1980.

2/"State Guide to Medicaid Cost Containment," Center for Policy Research, National Governors' Association (Grant No. 18-P-7490/3/01).

--restructuring program coverage so that care is delivered in an appropriate, but least expensive setting;

--minimizing eligibility errors;

--minimizing Medicaid's subsidy of other third parties; and

--maximizing the purchasing power of the State.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our objectives in this study were to (1) develop an inventory of court cases since 1973 that had the effect of blocking or delaying States' initiatives or policies aimed at controlling their Medicaid costs and (2) obtain information on States' experiences with increased flexibility in providing health care to the poor through the granting of waivers from Federal Medicaid requirements by HHS or in Arizona where such requirements are not applicable.

Regarding the first objective, we relied on the Medicare and Medicaid Guide (Topical Law Reports), published by the Commerce Clearing House, Inc. (CCH), of Chicago, Illinois. In addition to checking the topical indexes for court cases related to specific Medicaid regulations, we reviewed the "New Developments" from February 1973 to May 5, 1981, to identify cases pertaining to Medicaid during this 8-year period. This involved scanning nine volumes consisting of about 14,000 pages to identify the Medicaid-related court decisions at the time they were reported by the Topical Law Reports. Because of the vast volume of cases reported, we limited our discussions in this study to Federal court cases that pertained to a State practice or policy primarily involving class actions instead of cases involving alleged injustices to individual recipients. We also tried to limit our inventory to Federal requirements that were the issues in several court cases.

Because of the long period covered and the methodology used, there is no assurance that we identified all the cases pertaining to a specific issue or requirement, or that we identified all the decisions, including the appeals relating to the same case. However, in some instances, we contacted the State or HHS' General Counsel's office to obtain information on a case's current status. We did not attempt to evaluate the merits of the issues or to rationalize why the courts have appeared to come down on different sides of the same issue. Also, we made a limited literature search for the recent studies pertaining to possible strategies to increase States' flexibility in managing their Medicaid programs.

Concerning the second objective aimed at obtaining information on the States' experience with the waiver process, we limited our review to discussing the subject with officials in California and

Oregon, where our prior or ongoing work had indicated a high level of activity with the waiver process. We also visited officials in two counties in Arizona to develop information on how medical care is provided to the indigents in that State without a Medicaid program.

CHAPTER 2

STATE EFFORTS TO REDUCE OR TERMINATE BENEFITS

This chapter discusses situations in which States have been preliminarily or temporarily enjoined from reducing or terminating benefits or rates of payment because such action was judged by the Federal courts to violate Federal Medicaid law and/or regulations.

The most common cause of action (12 instances) involved in whole, or in part, the Federal Medicaid regulations (now 42 CFR 431.200-250) dealing with prior notice and opportunity for a hearing before the reduction or termination of benefits. These regulations can be traced to the landmark March 1970 Supreme Court decision (Goldberg v. Kelly). They also implement section 1902(a)(3) of the Social Security Act, which requires that a State's Medicaid plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted on promptly.

We identified at least nine States 1/ since 1973 whose cost saving initiatives or practices were delayed or blocked because of alleged violations of the pretermination notice and fair hearing requirements.

The second most common cause of action enjoining States from implementing cost saving modifications to their programs (of which several cases also involved the prior notice and/or fair hearing rules) involved the regulations requiring the establishment of Medical Care Advisory Committees (MCACs) to advise the Medicaid agency about health and medical care services (now 42 CFR 431.12). At least six States 2/ have been enjoined in part for violation of these rules.

Also, the optional eyeglasses programs in Pennsylvania and Vermont were enjoined in Federal courts because they were judged in violation of the Federal regulation (now 42 CFR 440.230) which provides, in part, that States may not arbitrarily deny or reduce the amount, duration, or scope of services solely because of the diagnosis, type of illness, or condition. Florida's limit on the number of physicians' visits was blocked on the same basis until reversed on appeal.

1/Connecticut, Florida, Illinois, Maryland, Mississippi, Missouri, New York, Ohio, and Pennsylvania.

2/Connecticut, Mississippi, New York, Ohio, Tennessee, and West Virginia.

In addition, in recognition of recent interest by the States in identifying Federal requirements which are preceived by them as barriers to efficient Medicaid operations, this chapter also includes the 1975 New York case involving the Federal requirement that Medicaid recipients have a free choice of providers. 1/

PRIOR INDIVIDUAL NOTICE AND RIGHT TO HEARING BEFORE REDUCTION OR TERMINATION OF BENEFITS

In addition to the 1976 Connecticut and Ohio cases and the 1977 and 1978 New York and Mississippi cases (see pp. 13 and 14) and the two Pennsylvania cases (see pp. 14 and 15), we identified at least five other instances in which States' cost saving activities were successfully challenged in the Federal courts because of their failure to provide notice to recipients and an opportunity for hearing before the reduction or termination of benefits. 2/ We identified one other case in which a State was enjoined under a different Federal rule involving adequate public notice of changes in statewide methods or levels of reimbursement.

The February 1971 Medicaid regulation 45 CFR 205.10, 3/ setting forth in some detail the procedures to be followed in providing individual recipients with prior notice and opportunity for a hearing before reducing or terminating benefits can be traced to the March 1970 Supreme Court decision--Goldberg v. Kelly (397 U.S. 254). This decision stated that procedural due process under the Constitution required that welfare recipients have timely and adequate notice detailing the reasons for a proposed termination and an opportunity to defend by confronting any adverse witnesses and by presenting their own arguments and evidence orally before benefits are terminated. The cases involving the prior notice issue are summarized as follows.

Florida--prescription drug allowance

In August 1973, a U.S. district court enjoined Florida from reducing Medicaid recipients' prescription drug allowances without first affording them advance notice and a fair hearing. At the time, the State allowed recipients a general maximum of $20 per month in vouchers to obtain prescription drugs, but also permitted "excess grants" in certain extreme life saving situations. It was

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1/Section 1902(a)23 of the Social Security Act and 42 CFR 431.51.

2/This excludes (1) cases where the issue involved individual recipients as opposed to a class of recipients or a State policy or practice and (2) cases in the State courts.

3/Now 42 CFR 431.200 et seq.

the reduction of these "excess grants" which was the issue in this case. In addition, the court ordered retroactive relief for unlawful reductions in allowances occurring after April 14, 1971.

Maryland--optional benefit reductions

In January 1976, Maryland, citing budget deficits, made across-the-board reductions in Medicaid benefits which included limiting (1) nonprescription drugs, (2) nonemergency dental care for people over 21, (3) podiatry services, and (4) eye examinations and eyeglasses. The changes were published in November 1975, and public hearings were held on December 1, 1975. However, notices were not sent to individual recipients until February 1976--after the cuts were effective.

In November 1976, a U.S. district court ruled that Maryland's notices were neither timely nor adequate under 45 CFR 205.10, but that recipients were not entitled to individual hearings because the reductions were across the board and there were no factual issues to be considered. Also, the court concluded that no retroactive financial relief could be required from the State. However, on appeal in June 1979, the appeals court ordered reinstatement of the pre-1976 benefits on a prospective basis and the continuance of such benefits to those eligible at that time (1976) until at least 10 days after each affected recipient had been mailed a State notice of any subsequent reduction. The court held that, because its order was entirely prospective, it was not barred under the doctrine of sovereign immunity. 1/

New York--transfer to lower level of nursing home care

In December 1976 and again in January 1978, New York was enjoined from transferring Medicaid recipients residing in skilled nursing homes to facilities providing a lesser level of care without first providing timely and adequate notice and an opportunity for a hearing as required by 45 CFR 205.10. The transfers had been ordered by the State as a result of utilization review requirements aimed at assuring that patients were receiving an appropriate level of care and that Medicaid resources were not being wasted.

In the 1976 decision, the court expressed its concern over the interpretation of the prior notification and fair hearing requirements and stated:

1/Under the 11th amendment to the Constitution, an unconsenting State is immune from suits brought in Federal court by a citizen.

"This is a case that does not belong in this court. It involves three governmental agencies--Federal, State, and city--and centers around regulations so drawn that they have created a Serbonian bog from which the agencies are seemingly unable to extricate themselves. An attorney representing one agency describes the situation as 'in a confusing state of flux,' a gross understatement. It is a mess. The city expresses concern that if it complies with the regulations as interpreted by the Federal Government it may not receive reimbursement from the State because the State differs from that interpretation. It borders on the absurd that Federal, State, and local officials charged with the administration of Social Security Act cannot reach an accommodation as to the meaning of the regulations which they drafted themselves, but instead force a court action for their interpretations."

Further, the January 1978 case has been the subject of litigation for a long time. For example, in October 1979, the U.S. district court set out a series of procedures to be followed and documentation to be required in the event that nursing home patients were to be transferred to a lower level of care as a result of utilization review activities, including patient access to all records on which to base their appeals. In August 1980, the U.S. court of appeals essentially affirmed the lower court's decision except for the part that dealt with an administrative review requirement, which would require the administrative decisionmaker, on an appeal from a hearing before the transfer, to read or listen to the entire transcript or tape recording of the hearing before issuing an administratively final decision.

Missouri--reduction of benefits without adequate notice

In July 1977, the Missouri Medicaid agency was permanently enjoined by a U.S. district court from discontinuing, suspending, terminating, or reducing AFDC and/or Medicaid benefits to recipients without timely or adequate notice.

According to the decision, the notice received by the recipients cited the applicable statute and informed them of their right to a hearing within 90 days; however, they were not informed of their right to a continuation of benefits pending a hearing if the request was made within 10 days. Since the regulations contemplate that a recipient requesting a hearing within 10 days will continue to receive benefits, the failure to include this provision in the notice made it inadequate. The State agency was ordered to send new notices, to reinstate benefits, and to grant pretermination hearings upon receipt of timely requests.

Illinois--reduction in nursing home rates

In November 1977, the Illinois Medicaid agency was preliminarily enjoined from reducing or terminating any rates or benefits paid or granted to nursing home or institutional recipients in such facilities under the State's "Hardship Rate Program" without prior notice and a right to contest the determination.

Essentially, the Illinois Nursing Home Hardship Rate Program was part of the Medicaid program and provided that, upon application, nursing homes treating Medicaid patients could receive rate increases if they met certain criteria. Of 215 homes applying for the hardship rates, 51 were granted increases. When two facilities were advised in June 1977 that they were being dropped from the hardship program, effective August 1, 1977, because their Medicaid occupancy levels were too low, the court action ensued which also included as plaintiffs the individual Medicaid patients in the institutions. The court concluded that both classes of plaintiffs were entitled to adequate and timely notice and opportunity for a hearing before the reduction or termination of rates under 45 CFR 205.10(a).

New York--termination of Medicaid benefits to SSI ineligibles

In September 1979, a U.S. district court concluded that the welfare agencies in New York had acted unlawfully by immediately terminating Medicaid benefits to aged, blind, and disabled individuals who had become ineligible for cash benefits under the Federal SSI program authorized under title XVI of the Social Security Act. Although Medicaid eligibility was categorically linked to SSI eligibility and the agencies had advised the terminated SSI recipients that they may reapply for Medicaid, the court ruled that, under the Medicaid regulation (42 CFR 431.202), the State must restore Medicaid benefits to this group until it gave each individual timely and adequate notice of the proposed termination of Medicaid and each individual was afforded an opportunity for a hearing to determine whether Medicaid eligibility exists separately from SSI eligibility. The decision pointed out that this could occur because (1) New York has a medically needy program whereby certain aged, blind, or disabled individuals can subtract their medical expenses from their income and still be eligible for Medicaid and (2) under section 503 of Public Law 94-566 and 42 CFR 435.135, a person who becomes ineligible for SSI due to a cost-of-living increase in Social Security benefits can remain eligible for Medicaid.

Pennsylvania--prescription drug copayment

In October 1979, Pennsylvania's Medicaid program was enjoined from imposing a 50-cent copayment for each drug prescription (with certain exceptions) because the State had failed to provide public

notice of the change pursuant to a Medicaid regulation (42 CFR 447.205) effective August 6, 1979, which required adequate public notice of changes in statewide methods or levels of reimbursement.

Also, because there were exceptions to the copayment plan, the court also concluded that under 42 CFR 431.220(a)(2), which requires fair hearings if any factual dispute can arise, the State must also provide for proper notice as to when recipients may or may not be entitled to a hearing on disputes.

MEDICAL CARE ADVISORY COMMITTEES

In at least six instances since 1976, States were preliminarily or temporarily enjoined from implementing cost saving modifications partially because of their failure to appropriately consult with duly constituted MCACs.

In February 1971, section 246.10 was added to the Federal Medicaid regulations; it required each State with a Medicaid program to establish an MCAC to advise the single State agency director on the program. 1/ The regulation provided that the MCAC members would include physicians and other health professionals and members of consumer groups, including Medicaid recipients and consumer organizations such as labor unions. These regulations also required that the MCAC have an adequate opportunity for meaningful participation in policy development and program administration, including the furtherance of recipient participation in the program. According to HCFA personnel, there was no specific statutory requirement for this regulation, but the requirement for MCACs had been included in the Medical Assistance Handbook 2/ since 1965 and was converted to a regulation in 1971.

In January and May 1976, Connecticut and Ohio, respectively, were temporarily or preliminarily enjoined from reducing fees paid to noninstitutional providers or from eliminating some optional services, such as nonprescription drugs, dental, optometric, and podiatry services, because the State agency had not provided adequate and timely notice to recipients of the cutbacks (45 CFR 205.10) and had not provided for meaningful participation of an MCAC.

In the Ohio case, the district court concluded that, while the notice was timely, it was not adequate because it failed to provide for a prereduction hearing for those recipients who wished to assert that their affected services were not optional. For example, services that are usually optional may not be for a recipient under the

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1/Now 42 CFR 431.12.

2/Handbook of Public Assistance Administration, Supplement C: Medical Assistance Programs.

mandatory Early and Periodic Screening, Diagnosis, and Treatment program.

In August 1978, the May 1976 injunction against Ohio was reversed upon appeal because the Court of Appeals held that (1) the notice of the reduction in optional benefits was adequate and notice of an opportunity for a hearing for each recipient did not apply when State law or policy was involved and (2) the MCAC was sufficiently advised of the problems and the State did not have to obtain the Committee's consent to the reduction of optional benefits.

In June 1977, New York was enjoined from implementing a State statute authorizing copayments for drugs and medical supplies because sufficient notice was not provided to recipients and the decision was made without consultation with an MCAC. In October 1978, Mississippi was enjoined from reinstituting a 50-cent copayment on drugs because adequate notice was not provided to recipients and the composition of the MCAC was discriminatory and underrepresented consumer groups.

In July and September 1980, West Virginia and Tennesse, respectively, were preliminarily enjoined in the Federal courts from reducing coverage and levels of reimbursement because the States failed to consult with their MCACs.

PENNSYLVANIA'S COVERAGE OF EYEGLASSES

Since 1976, Pennsylvania's efforts to limit or terminate its optional eyeglass benefit have been subject to a series of Federal court injunctions because of violations of Federal Medicaid regulations. Three years later, Vermont's eyeglasses program was successfully challenged in U.S. district court on the same basis as Pennsylvania's was initially enjoined.

In April 1976, the Pennsylvania State Medicaid agency was enjoined from enforcing its rule which provided coverage of eyeglasses to eligible individuals suffering from eye disease or pathology while denying coverage for correcting refractive errors, in part because the State rule was in conflict with a Federal regulation (45 CFR 249.10(a)(5)). 1/ This regulation provided that a State could not arbitrarily deny or reduce the amount, duration, or scope of services solely because of the diagnosis, type of illness, or condition. The State appealed, and in May 1977, the district court judgment was affirmed.

After the above decision, Pennsylvania decided to eliminate the optional eyeglasses program entirely, citing substantial

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1/Now 42 CFR 440.230.

budget deficits. The program was terminated effective September 30, 1977.

Following an April 1978 Federal court decision enjoining the State fro terminating its orthopedic shoe program because of failure to comply with the individual notice requirement (45 CFR 205.10(a)(4)), 1/ action was brought to challenge the State's termination of the eyeglasses program on the same basis. In December 1978, the district court refused to enjoin the termination because the underlying eyeglasses benefits program had been previously judged illegal. However, upon appeal, this decision was vacated in November 1979, and the case was returned to the district court with the directive that the State be enjoined from terminating its eyeglasses program until it had complied with the notice requirement of 45 CFR 205.10 (1978). In May 1980, the district court issued such a preliminary injunction.

As of April 1981, Pennsylvania continued to provide eyeglasses in accordance with the court order.

In October 1979, Vermont's program for eyeglasses and related services, which covered such services for people with eye surgery or diseases while denying payment for this care to correct refractive error, was judged illegal for violating essentially the same regulation (now 42 CFR 440.230(c)(1)) as Pennsylvania's program was originally enjoined for violating in April 1976. 2/

Also, in April 1979, Florida's limitation of physician services to three visits per month was permanently enjoined by a U.S. district court, in part because the limitation was contrary to the 42 CFR 440.230(c)(1) requirement that the amount, duration, or scope of service not be denied solely because of the diagnosis, type of illness, or condition. The State appealed, and in September 1980 the district court decision was reversed because under Florida's limits no particular medical condition had been singled out for unique treatment.

1/Now 42 CFR 431.200 et seq.

2/In August 1977, the U.S. district courts required Georgia and Minnesota to cover sex conversion surgery under the same regulation. In September 1980, the Georgia case was reversed and remanded upon appeal.

FREEDOM OF CHOICE OF PROVIDERS 1/

In April 1975, New York City advertised for bids to competitively contract for clinical laboratory services under its Medicaid program. Potential bidders were invited to submit bids on any or all of the city's five boroughs. Successful bidders, however, could be awarded exclusive contracts covering no more than two boroughs.

A sequential system of bid openings was designed based on the decreasing order of each borough's Medicaid population. As bidders were awarded particular boroughs, they became ineligible for further awards--even though they may have been the low bidder. This procedure was followed to maximize laboratory participation in the award process. Because of its low Medicaid population, Staten Island was awarded last and to the lowest bidder regardless of prior awards.

The bidders were required to submit two price quotations, a maximum aggregate fee and a unit price for each test. The maximum aggregate fee represented the fixed ceiling price for which the contractor agreed to provide all clinical laboratory services requested within the designated borough during the stipulated period. This amount was to be the basis of the contract award.

However, a coalition of clinical laboratories sought a Federal court injunction to prevent contract implementation based in part on the contention that the proposed contract was contrary to Federal law because it violated a Medicaid recipient's right to choose a laboratory. HHS filed a friend of the court brief in support of the plaintiffs. At the same time, HHS recommended that the city contract for such services on an experimental basis for a limited time using the Department's authority to waive statutory requirements for demonstration projects.

In August 1975, the court concluded that, in effect, the city's authority to enter into its proposed exclusive contract plan to provide laboratory services might be contrary to Federal law, but recognized that some benefits might be derived from the contracting arrangement. Specifically, the court noted that in 1974 the city had paid about $10.5 million to clinical laboratories under Medicaid and that the aggregate maximum bids received were about $5.1 million less. The court permitted the city to pursue a contract on an experimental basis in one borough (Queens). However, the city did not pursue this option.

1/As noted on page 4, the HHS May 15, 1981, proposed bill would replace the freedom of choice provision with a requirement to provide such standards as could reasonably be expected to afford recipients covered medical care of adequate quality.

SUMMARY

To a large extent, challenges in the Federal courts to State efforts to reduce or terminate benefits have involved, at least in part, procedural due process issues under the Constitution, which are not susceptible to waiver through legislative or administrative action. Therefore, if the States are to be given greater flexibility in managing their Medicaid programs to minimize or control costs, considerable care would be required in how State initiatives are implemented to avoid situations where such action could be successfully challenged on due process grounds.

CHAPTER 3

COST-BASED PROVIDER REIMBURSEMENT

The Social Security Amendments of 1972 (Public Law 92-603) contained two amendments that affected States' authority to establish reimbursement rates for hospitals and nursing homes under their Medicaid programs.

One amendment (section 232) dealt with the payment of reasonable costs of inpatient hospital services and authorized the States to develop methods and standards for determining such costs subject to HHS approval. 1/ Before that time, States were generally required to use Medicare methods and standards for reimbursing the costs of inpatient hospital care.

Another amendment (section 249) dealt with payments to nursing homes and provided that, effective July 1, 1976, the payment for nursing home care under Medicaid would be on a "reasonable cost related basis" determined in accordance with methods and standards developed by the State on the basis of cost-finding methods approved by HHS. 2/

As discussed below, Wisconsin, California, Illinois, and New York have been enjoined or delayed in implementing hospital reimbursement methods, and Alabama and Florida have been subject to lengthy litigation over their implementation of section 249. 3/

HOSPITAL REIMBURSEMENT ISSUES

The cases discussed below focus on States' efforts to either "freeze" or place upper limits (ceilings) on Medicaid reimbursement to hospitals.

1/Section 1902(a)(13)(D). The HHS May 15, 1981, proposed bill would repeal this.

2/Section 1902(a)(13)(E). The HHS proposed bill would also repeal this.

3/Section 962 of the Omnibus Reconciliation Act of 1980, approved on December 5, 1980, modified this provision to authorize the States to establish payment rates which the State finds and make assurances satisfactory to HHS are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities * * *."

Wisconsin--freeze on reimbursement for inpatient hospital services enjoined

In December 1974, the Wisconsin State Medicaid agency ordered a freeze on all rates and fees paid to providers. The Wisconsin Hospital Association moved for a preliminary injunction in November 1975, and on December 25, 1975, a U.S. district court granted a preliminary injunction ordering the State to reimburse the plaintiffs on the basis of reasonable costs. On April 28, 1976, the court made the injunction permanent.

California's limits on increases in inpatient hospital reimbursement blocked

In March 1975, California submitted to HHS a proposed plan for reimbursing hospitals under Medicaid which included a percentage ceiling on increases in a hospital's average daily reimbursable costs over the cost of the preceding year. The ceiling for the period July 1975 through June 1976 was 110 percent of a hospital's costs during the preceding fiscal year. HHS approved the California plan on March 31, 1976.

In November 1976, a U.S. district court held the plan invalid based on its opinion that the Medicaid law and its implementing regulations did not permit a ceiling on reimbursable costs and because California's plan had not been properly approved by HHS. The court concluded that the ceiling on reimbursable costs did not meet the HHS regulations requiring that a State reimbursement plan provide "incentives for efficiency and economy" (45 CFR 250.30(a)) and the State was enjoined from implementing its plan.

Meanwhile, in July 1976, the U.S. district court ordered a preliminary injunction to the effect that California could not enforce its Medicaid regulation that would limit increases in reimbursement for inpatient hospital services for the period July 1976 through June 1977 to 7 percent over the cost for the previous year.

In August 1979, the U.S. court of appeals reversed the district court with respect to the July 1975-June 1976 limits by ruling that the Medicaid law did authorize HHS to approve provisions in State plans which place ceilings on reimbursable costs. Conversely, the court of appeals affirmed the lower court's conclusion that the plan had not been properly approved by HHS. According to the appeals court, the State's plan was made up of two parts--the first consisting of a one-page, four-paragraph statement outlining the proposal--and the evidence showed that HHS confined its review and approval to this part. The court held that the failure to also review and approve the appendix (part 2) to the proposal, which disclosed that the ceiling was limited to increases from anticipated inflation and was based on a formula that considered

neither changes in service intensity nor variations in cost structures of different hospitals, resulted in a review that fell short of the statutory requirement.

According to a California official, the State resubmitted its proposal, which was approved by HHS in May 1980, effective July 1, 1980.

Illinois--freeze on hospital reimbursement rates blocked

In October 1975, Illinois initiated certain policies regarding hospital reimbursement which included a moratorium on adjustments in the Medicaid interim reimbursement rates and which were allegedly accompanied by (1) the State agency's failure to make yearend cost report settlements 1/ with hospitals and (2) delays in payments.

Hospitals in the State filed a motion in a U.S. district court for a preliminary injunction the same month, and a hearing on a renewed motion for an injunction was held in October 1976--a year later.

Before a final judgment, however, the hospitals and the State agency executed a settlement agreement on March 25, 1977. Based on this agreement, the court issued a consent decree to the effect that

--the State agency would not implement its October 1975 reimbursement policies and

--time frames were agreed upon for establishing interim payment rates based on current cost data and for making final settlements based on the hospital's actual reasonable costs using Medicare's cost reimbursement principles.

New York--payment of less than reasonable costs for inpatient hospital services enjoined

Since 1970, New York had used a prospective method of reimbursing for inpatient hosptial services instead of the traditional retrospective method used under Medicare.

1/A process whereby hospitals file a report on their actual costs at the end of a fiscal year; the differences between the interim payments and the actual costs are paid to the institution if the actual costs are higher or by the institution if the actual costs are lower than the interim payments.

In July 1976, a U.S. district court enjoined New York from enforcing three State reimbursement rules effective January 1, 1976, which allegedly resulted in Medicaid payments for inpatient hospital services which were less than reasonable costs, unless or until such methods of payment were approved by HHS as required by section 1902(a)(13)(D) and 45 CFR 250.30. On August 2, 1976, the State was ordered to recompute and pay for services rendered on and after January 1, 1976, in accordance with the version of the existing (1975) State reimbursement plan that had been approved by HHS.

On August 16, 1976, however, HHS had approved two of the three new State rules, and the State questioned whether such approval could be considered retroactive to January 1, 1976, and also requested and was granted a stay of the earlier order to recompute the payment rates until this retroactivity question was resolved. The stay, dated September 28, 1976, also provided, however, that if the State eventually had to pay the higher, recomputed rates, it must also pay interest to the hospitals. On November 9, 1976, the district court concluded that the State rules could not be applied retroactively, but may be applied only from the date they were approved by HHS. The court directed the State to comply with the original August 2, 1976, order and pay the hospitals on the basis of the 1975 plan for the period January 1 to August 16, 1976.

On November 19, 1976, the State moved for a stay in judgment, which was denied on November 22. On December 14 the court of appeals also denied the State's application for a stay.

On January 13, 1977, the Health and Hospital Corporation (HHC)--which operated 17 public hospitals in New York City--moved to hold the State officials in contempt because the methodology used to recompute the rates for its facilities was not in accordance with the original August 2 order.

On February 14, 1977, the district court refused to hold the officials in contempt, but concluded that two features of the methodology used to compute the HHC hosptials' rates were not consistent with the August 2 order. One feature related to the application of reimbursement ceilings for voluntary hospitals to the HHC rates, and the second to the exclusion of HHC costs for calculation of HHC reimbursement ceilings. The State was ordered to recalculate the reimbursement rates for HHC hospitals from January 1 to August 16, 1976, in accordance with this opinion and all prior court orders.

The State appealed and on March 16, 1977, the court of appeals remanded for the district court's consideration the question of whether Public Law 94-552, which repealed section 1902(g) of the

Medicaid law, affected the validity of the August 2, 1976, judgment. 1/ On August 5, 1977, the district court concluded that:

(1) The August 2 judgment, insofar as it grants monetary relief against New York State, must be vacated, and

(2) the State's motion to dismiss the hospitals' claims for monetary relief against the State must be granted.

The hospitals then moved for a summary judgment against the Secretary of HHS on the basis that the Department's August 16, 1976, approval of the State plan had been arbitrary and capricious. On October 14, 1977, the motion was denied, but the suit against HHS continued to determine whether the Department's approval was based on due consideration of the criteria established by 45 CFR 250.30 (1976).

On April 25, 1979, the district court concluded that HHS' approval of New York's 1976 reimbursement plan was not arbitrary or capricious except for that portion which had reduced reimbursement of hospital interns' and residents' salaries from 100 to 90 percent.

NURSING HOME REIMBURSEMENT ISSUES

The nursing home reimbursement cases essentially involved the legality of the effective date of HHS regulations and the methodology a State used to compute payment rates.

Alabama's implementation of cost-based reimbursement for nursing homes

Section 249 of the Social Security Amendments of 1972, requiring States to reimburse nursing homes on a reasonable cost-related basis, contained an effective date of July 1, 1976. However, HHS' final regulations issued on July 1, 1976 (45 CFR 250.30 (a)(3)(iv)), gave the States until January 1, 1978, to comply.

1/Public Law 94-182, effective January 1, 1976, added section 1902(g) to the Social Security Act, which provided that State Medicaid plans must include a consent by the State to the exercise of the judicial power of the United States in any suit brought against the State on behalf of institutional providers of service with respect to the application of section 1902(a)(13)(D) and the waiver by the State of any immunity from such suit conferred by the 11th amendment to the Constitution. By Public Law 94-552 enacted October 18, 1976, the above provision was repealed effective January 1, 1976.

In February 1977, the Alabama Nursing Home Association filed suit in a U.S. district court challenging the regulations and the fact that, although Alabama was paying nursing homes on a cost-related basis, the payments were subject to an absolute ceiling of $21.50 a patient day for skilled nursing facilities (SNFs) and $19.35 a day for intermediate care facilities (ICFs), which were not cost related.

On July 12, 1977, the district court concluded that the regulations--which gave the States until January 1, 1978, to comply with the statute--were invalid because HHS had no power to override acts of the Congress or to exempt the States from their effect by specifying a different effective date.

The court required (1) the State to submit a plan conforming to section 249 within 60 days and (2) HHS to approve any conforming plan within a reasonable time. No retroactive financial relief was requested or granted.

The conforming plan was filed and approved by HHS in December 1977.

Generally, Alabama's plan provided for three classes of nursing home providers: (1) SNFs, (2) ICFs, and (3) a combination facility offering both levels of care. A per diem ceiling was set at the rate equal to the 60th percentile of the costs for facilities in each class; this produced reimbursement limits of $24.00 per patient per day for SNFs, $20.44 a day for ICFs, and $22.87 a day for a combination facility. Limits were also imposed for specific items of costs, such as consultant services, interest, and depreciation.

In March 1978, the Nursing Home Association filed a supplemental complaint with the U.S. district court challenging the plan partially on the basis that it was not "reasonable cost-related" within the meaning of section 249. In a February 23, 1979, opinion, the court concluded that the plaintiffs had not demonstrated that Alabama's plan failed to meet the provisions of the Federal statute and also ruled for the State on the question of whether it had violated the assurance-of-payment provision in its plan by failing to appropriate sufficient funds for its Medicaid program. 1/ The court also concluded that HHS had not violated its duties in approving the plan.

The nursing homes appealed, and in a May 7, 1980, decision, the court of appeals reversed the district court's judgment on the issue of HHS' failure to perform its statutory and regulatory

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1/42 CFR 450.30, which provides in effect that States come up with the money to adequately carry out their Medicaid program and pay providers in accordance with the approved plan.

duties in approving the plan. Among other things, the court held that HHS failed to define an "efficiently and economically operated" institution despite the fact that the minimum level of reimbursement is to be measured by the full, actual allowable costs of such an institution.

Because it concluded that HHS had failed to meet its obligation in approving the plan, the court of appeals also vacated that portion of the district court decision that the plan met the requirements of section 249.

Concerning the assurance-of-payment question, the court of appeals also vacated that portion of the earlier decision citing certain events, such as a 10-percent cutback on reimbursement payments in August and September 1977 and a budget deficit of $4.9 million in fiscal year 1978.

The court of appeals returned the case to the district court for further proceedings consistent with its opinion.

According to an HHS attorney, in July 1980 the district court directed HHS to review the Alabama plan in light of the appeals court decision and to report back on the progress within 6 months (January 1981). The plaintiffs requested a more specific deadline for approving or disapproving the plan, which has been extended to May 31, 1981.

Florida--implementation of cost-based reimbursement for nursing homes

On October 18, 1977, a U.S. district court in Dade County, Florida, acting on a suit brought by certain nursing homes in the district, concluded that the Federal regulations implementing section 249 were invalid insofar as they establish an effective date other than July 1, 1976, as required by law. The court ordered HHS to determine whether the existing Florida reimbursement plan complied with section 249 and to advise the court by October 28, 1977. 1/ The court further directed that, if HHS found lack of compliance, the State had to submit a plan to HHS for approval by November 17, 1977. Such plan had to provide for reasonable cost-related reimbursement beginning October 18, 1977, and other questions concerning retroactivity were reserved.

Other nursing homes in the State, through the Florida Nursing Home Association, later joined in the case and were covered by the order requiring the State to reimburse the State's Medicaid nursing

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1/Similar district court decisions regarding the effective date of implementing section 249 have involved Illinois, Nebraska, and Wisconsin.

homes on a "reasonable cost-related" basis from October 18, 1977, prospectively. The district court denied retroactive relief for services rendered before that date.

Both Florida and the Nursing Home Association appealed. The State appealed partially on the basis that the district court did not have jurisdiction, and the nursing homes appealed on the basis that their claim for reimbursement on a reasonable cost-related basis before October 18, 1977, had been denied.

On May 16, 1980, the court of appeals affirmed the lower court's judgment regarding the State's appeal and reversed the court's judgment regarding the nursing homes' appeal. On the latter issue, the appeals court concluded that the doctrine of sovereign immunity embodied in the 11th amendment to the U.S. Constitution does not bar a Federal court from ordering compliance with a Federal statute because the State has waived its immunity by contracting with HHS to be bound by all Federal laws applicable to the Medicaid program. The effect of this decision was to require Florida to reimburse Medicaid nursing homes on a reasonable cost-related basis retroactive to July 1, 1976. The State appealed to the Supreme Court. On March 2, 1981, the Supreme Court concluded that Florida had not waived its immunity under the 11th amendment by mere participation in the Federal Medicaid program; therefore, retroactive financial relief to the nursing homes was denied.

SUMMARY

As illustrated in the California hospital reimbursement and the Alabama nursing home reimbursement cases, the fact that HHS has approved a State's plan as required by the law does not necessarily preclude the State's action from being blocked because the courts may find the approval lacking.

CHAPTER 4

CHALLENGES TO STATE RULES PERTAINING TO MEDICAID ELIGIBILITY

Perhaps the most complex feature of the Medicaid program pertains to the various Federal requirements involving eligibility which in turn are tied into the cash assistance programs authorized by the Social Security Act--specifically, the federally assisted, State-operated AFDC program authorized by title IVA and the Federal SSI program authorized by title XVI.

In this chapter we discuss Federal court cases pertaining to three issues that our research indicated were particularly troublesome in terms of States' efforts to (1) minimize costs by restricting eligibility and/or (2) simplify program administration. These issues involve:

--The administration of the Federal spend-down requirements. (See below.)

--State rules aimed at prohibiting individuals from transferring their assets to others at less than fair market value in order to become eligible for Medicaid. 1/

--The administration of Federal rules pertaining to "deeming," whereby the income of one spouse is "deemed" to be available to the other.

Because many of the rules pertaining to these issues are related to the Federal SSI program, which became effective January 1, 1974, this chapter only includes cases since that date.

DISPUTES PERTAINING TO STATES' ADMINISTRATION OF THE "SPEND-DOWN" REQUIREMENTS

Under two Medicaid eligibility options available to the States, individuals are permitted to subtract the medical expenses from their income in order to become eligible for Medicaid. First, a State can choose to cover the "medically needy," who are individuals with too much income or resources to be eligible for AFDC or SSI but too little to pay for their health care. The medically needy must be permitted to deduct from their income medical expenses they incur a liability to pay when determining if they meet

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1/Sections 5(a) and (b) of Public Law 96-611 approved December 28, 1980, substantially modified Federal requirements in this area.

the income eligibility level for Medicaid. This subtraction process is known as "spending down to the eligibility level" or simply the "spend-down program." Medicaid regulations (42 CFR 435.800-.816) require that the amount of income to which the medically needy are required to spend down cannot be less than the payment standard for an AFDC family of the same size or the income standard for SSI in the case of individuals and couples if that amount is lower than the AFDC payment standard.

The second eligibility option the States can choose which results in a mandatory spend-down program is authorized by section 1902(f) of the act and relates to SSI recipients. A State can determine Medicaid eligibility for SSI-type individuals as long as the criteria are not more restrictive than those used on January 1, 1972, for aged, blind, and disabled people. If a State chooses this option, it must permit all aged, blind, and disabled people to spend down to the Medicaid eligibility level (42 CFR 435.121).

New York's method of administering the spend-down challenged

In November 1975, a U.S. district court concluded that New York's method of computing the maintenance allowances for the medically needy was invalid because it allowed them to retain less than the applicable standard of need under the State's AFDC cash assistance program.

In New York, each AFDC family of the same size received a basic cash allowance of the same amount, plus an allowance for shelter based upon actual rent paid up to the maximum set for shelter in a given family's area of residence. However, to arrive at the level of income to be protected for maintenance for the medically needy under Medicaid, the State agency averaged the shelter allowance paid to all AFDC families of a given size and divided by the number of those families. The resulting "mean shelter allowance" was then added to the basic AFDC allowance to determine the income that could be retained by a medically needy family of that size. Thus, some medically needy families were entitled to retain more and others less income for maintenance than they would have been allowed under AFDC.

The court ordered New York not to enforce the State statute and regulations, but to compute income protected for maintenance in amounts no less than those allowed to be paid to comparable AFDC recipients.

Further, in November 1977, a court of appeals affirmed a lower court's decision that New York's methods for deducting from income the work-related expenses of the medically needy under

Medicaid were also in conflict with Federal law and regulations because the methods involved different and more restrictive standards than those applied in determining eligibility for AFDC.

Illinois spend-down methods required modification

Illinois has a medically needy program and also elected to determine Medicaid eligibility under 1902(f). In April 1980 a U.S. district court ruled that Illinois' methods for computing the income to be protected for aged, blind, and disabled medically needy Medicaid recipients were not consistent with the law and regulations providing that the level to which the medically needy are required to spend down be no lower than "the most liberal money payment standard used by the state" in determining cash grant assistance to the categorically needy.

In Illinois, according to the decision, eligibility for cash welfare grants was determined on an individualized basis. Both the basic needs--shelter, utilities, food, and clothing--and special needs were incorporated into the standard. To simplify program administration for the medically needy under Medicaid, however, the State translated this individualized standard into flat rates which failed to consider all the special needs that were factored into the cash assistance standards.

The court did not strike down the Illinois system, however. It merely required that the State adopt some process whereby medically needy applicants have an opportunity to bring to the State agency's attention any special needs which would allow them to retain more of their income. Essentially all this opinion required was that a formula be devised which ensures that no medically needy recipient be placed in a less favorable position than the categorically needy.

Ohio's income eligibility limits enjoined

Under certain conditions, States may impose more restrictive Medicaid income eligibility conditions than are required for cash payments under the Federal SSI program. The States that exercise this option must, among other things, deduct from income certain medical expenses (the spend-down) incurred when determining whether individuals meet State income eligibility criteria (42 CFR 435.732). Although Ohio did not have a medically needy program, it did restrict Medicaid eligibility for SSI recipients by using more restrictive criteria than SSI, and the State was enjoined in a Federal court for its administration of the spend-down provision under Medicaid.

1/Section 1902(a)(10)(c)(i) and (17)(B); 42 CFR 448.3(c)(3)(i) (1977).

Ohio had established a gross income ceiling in determining financial eligibility for SSI-related cases. Applicants with income above the ceiling were not permitted to deduct medical expenses from income before income eligibility was determined. In February 1977, a U.S. district court permanently enjoined Ohio from enforcing those State provisions because they violated Federal requirements.

The court ruled that, in accordance with Federal requirements, the medical expenses of an eligible aged, blind, or disabled person must be deducted from income before income eligibility is determined. The court said that the recipient in this case remains eligible as long as his net income thus determined does not exceed the State's income eligibility standard for institutionalized individuals. Although this case was not a class action, the court noted that "the declaratory judgment aspect of this order will require the defendents to modify their treatment of all those who are similarly situated in a manner not inconsistent with said declaratory judgment."

In June 1977, 4 months later, Ohio was back in court on the same issue. This time, however, the case was a class action. The court again found that Ohio's Medicaid regulation conflicted with Federal law to the extent that it set a gross income ceiling without allowing spend-down. Class action was granted, and the agency was enjoined from terminating or denying eligibility without first making a medical expense determination in accordance with the law and regulation.

TRANSFER OF ASSETS

Courts have generally supported the Federal requirement (42 CFR 435.700 and 435.721) that States using SSI eligibility criteria for Medicaid eligibility must not impose transfer-of-asset restrictions on Medicaid applicants that were more restrictive than SSI criteria. States not using SSI criteria for Medicaid eligibility, however, have been permitted to establish more restrictive eligibility requirements, providing certain conditions were met.

SSI eligibility criteria regarding transfer of assets changed substantially effective March 1981, under the provisions of Public Law 96-611 (sections 5(a) and 5(b)) passed in December 1980. Previously, SSI applicants were permitted to transfer assets for less than reasonable consideration for the purpose of becoming eligible for SSI. The new law provides that assets transferred at less than fair market value within 24 months preceding application for SSI or Medicaid may be included as part of the applicant's resources.

In addition to modifying the SSI criteria, Public Law 96-611 added a subsection to the Medicaid law effective July 1, 1981, which allows States to implement transfer-of-asset provisions that are more restrictive or more liberal than SSI criteria. Provided that the uncompensated value of disposed resources exceeds $12,000, the State may provide for a reasonable period of ineligibility in excess of 24 months.

In view of these changes, the issues to be submitted to the courts in 1981 and later years may well be different than those submitted in the past. However, the courts have, in the past, sustained the California transfer-of-assets law, 1/ but have struck down those in Connecticut, New York, and Maryland. These issues are discussed briefly below.

Availability of transferred assets

One issue on which the courts have ruled on both sides relates to whether assets transferred without reasonable consideration should be considered actually "available" to the Medicaid applicant. Section 1902(a)(17)(B) specifies that only such income and resources which are "available" to the applicant or recipient shall be used in determining eligibility. In different cases transferred assets were both considered and not considered "available."

In 1976, a U.S. district court in Connecticut ruled against a Connecticut transfer-of-assets law. The court said that the State law presumed that the assets were still available to the transferor. According to the court, this presumption may not only be "cruel and irrational" in many cases, but also nothing in the Social Security Act, or its regulations or legislative history, authorizes such a presumption. In 1977, the Supreme Court affirmed this decision that Connecticut's transfer-of-assets requirements were unlawful and unenforceable.

In May 1980, a U.S. court of appeals in California upheld a district court ruling which let stand the California transfer rule. The appeals court, however, recognized that most courts reviewing similar issues have reached opposite conclusions. The court ruled that, among other things, the State was not bound to consider only those assets for which the applicant has present record title or ownership; the State could consider assets which had apparently been transferred so that the applicant could meet the eligibility requirements for Medicaid.

1/ In May 1981, the Supreme Court vacated a May 1980 California decision and sent the case back to the Federal appeals court to study what impact this new Federal law will have on the controversy.

Comparable eligibility requirements for medically needy

The same Federal courts in California also disagreed with other courts regarding the Federal provision that the medically needy must meet "comparable" eligibility requirements to the SSI program (section 1902(a)(10)(C)). The court of appeals said that "comparable" does not mean "identical"; it only means that there must be enough similar characteristics or qualities to make comparison appropriate. The provisions in the California plan, they said, met this definition of "comparable." In May 1981, the Supreme Court vacated and remanded the appeals court decision.

In contrast to the court of appeals in California, in April 1980, a U.S. court of appeals in New York upheld a December 1979 lower court decision which issued a preliminary injunction prohibiting the State from enforcing its transfer-of-assets law until it decided whether the State eligibility requirements for medically needy were not "comparable" to those for categorically needy because they placed transfer-of-assets prohibitions on the medically needy while the categorically needy were not subject to the transfer-of-assets rule under SSI criteria. In May 1980, the Supreme Court denied New York's attempt to obtain a stay of the order enjoining State enforcement of the transfer rules. The Court refused to permit enforcement even though the State argued that failure to enforce the transfer-of-assets rules cost the State $150 million annually. Further, in November 1980, the district court denied a petition by the State to modify the preliminary injunction. The State had argued that, because it had elected in April 1980 to use eligibility requirements more restrictive than SSI's, the legal bases for the December 1979 injunction had been removed. In June 1981, the Supreme Court denied certiorari in the case.

Related to the above-cited section of the law pertaining to "comparability" is a regulation providing that the State must not use eligibility requirements for medically needy aged, blind, and disabled individuals that are "more restrictive" than those used under SSI (42 CFR 435.401(c)). The district court in the California case cited above concluded that this section may apply to certain eligibility requirements but not those relating to financial eligibility. Although the appeals court disagreed, as previously noted, its decision was vacated in May 1981 by the Supreme Court.

However, in May 1979, a U.S. court of appeals in Maryland used this regulation as a basis for enjoining Maryland's enforcement of its transfer-of-assets law. The court ruled that Maryland's transfer law clearly imposed more restrictive eligibility criteria on medically needy aged, blind, or disabled individuals than on SSI recipients.

DEEMING OF INCOME

Deeming the income of one person to be available to pay another person's medical bills is permitted under certain conditions by Federal regulations. 1/ Some States have considered a portion of one spouse's income as available to the other spouse, whether or not the income was actually contributed, and reduced in advance the Medicaid payment for the treatment of the other spouse.

We identified 14 instances involving at least 12 States in which the courts have either ruled against deeming or temporarily enjoined the enforcement of regulations authorizing deeming. The primary reason cited for the rulings was that deeming is inconsistent with statutory language requiring income to be actually "available" to the Medicaid applicant or beneficiary (section 1902 (a)(17)(B)). According to the statute, State Medicaid plans must "provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient * * *." The income of one person may or may not be considered "available" to another. For example, if a husband is either unable or unwilling to contribute toward the medical bills of his wife, the husband's income may not actually be considered "available."

Some decisions have come down against deeming in terms of establishing eligibility or reducing Medicaid payments. However, these decisions allow the States to use their relative responsibility laws to enforce financial responsibility because the Medicaid statute and regulations do not preclude States from enacting laws of general responsibility of spouses and parents concerning retroactive recovery of the costs of medical assistance furnished by the States to recipients. Decisions involving Indiana in January 1980, Minnesota in May 1979, and Connecticut in September 1977 indicated that States should use their relative responsibility laws to recover medical payments from relatives rather than deem their income available for such payments.

Other decisions have gone against States using arbitrary formulas for deeming availability of income but have contained language that would give the States some discretion to make a reasonable evaluation of income and expenses needed by the parties before deeming income of one person available to another. Such

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1/See 42 CFR 435.120, 435.121, 435.602, 435.734, 436.602, 436.711, and 436.821.

decisions occurred in Iowa 1/ in March 1980, Mississippi in January 1980, Ohio in April 1979, Oregon in May 1975, North Carolina in March 1979, and Texas in August 1976.

Decisions in other States went against deeming, but did not indicate what recourse, if any, a State has for enforcing the financial responsibility of family members. These decisions, which involved Utah in August 1979, Florida in May 1977, and New York in May 1979, did not indicate an acceptable way in which the States could require relatives to contribute to medical expenses.

The case that may have the greatest impact regarding deeming is Gray Panthers v. Secretary, Department of Health, Education, and Welfare (Dec. 8, 1978). The District Court for the District of Columbia in this case found the regulations (42 CFR 435.734, 436.602, 436.711, and 436.821) which allow a State to deem income from a noninstitutionalized spouse to be available to an institutionalized spouse in a Medicaid nursing home to be inconsistent with the Medicaid statute regarding availability. The court ordered the Secretary to (1) rescind the offending regulations, (2) require all relevant jurisdictions to cease the deeming of income, for any length of time, between institutionalized Medicaid recipients or applicants and their noninstitutionalized spouses, and (3) promptly propose and publish new regulations which conform with the statute. The Secretary appealed the decision.

1/One of the judges who dissented in the Iowa case made the following comments about the complexity of the statutes:

> "Unfortunately, [s]ince the welfare statutes now rival the Internal Revenue Code in complexity, one interprets them with less robust confidence." Lynch v. Philbrook, 550 F.2d 793, 795 (2d Cir. 1977). "As program after program has evolved, there has developed a degree of complexity in the Social Security Act and particularly the regulations which makes them almost unintelligible to the uninitiated." Friedman v. Berger, 547 F.2d 724, 727 n.7 (2d Cir. 1976), cert. denied, 430 U.S. 984 (1977). "This [is] particularly true in the present case, which required unraveling the relationship between two Social Security programs, Supplemental Security Income (SSI) and Medicaid. Moveover, an examination of case law reveals that the courts have been less than uniform in their analysis of deeming and related questions." Compare Brown v. Stanton, No. 79-1459 (7th Cir. Jan. 30, 1980) with Norman v. St. Clair, No. 77-1722 (5th Cir. Jan. 28, 1980).

On July 29, 1980, the U.S. Court of Appeals for the District of Columbia Circuit issued its decision in the Gray Panthers case, agreeing with the district court that income deemed available must actually be available. In addition, the court of appeals concluded that the Department "has failed to consider all the relevant factors in determining whether 'deeming' is proper in this context." The court remanded the case to the district court which, on October 8, 1980, remanded the matter to the Secretary for consideration consistent with the court of appeals' order that the relevant factors be considered in issuance of regulations governing deeming. The district court ordered publication of a final rule by December 11, 1980, reflecting the court of appeals decision. The Department issued new regulations on December 15, 1980.

The decision in the Gray Panthers case and the resulting changes in the regulations involve only the States 1/ that use more restrictive eligibility criteria than those applied under the SSI program. The new regulations give these States the option of (1) using SSI criteria for determining the availability of income, (2) using criteria more liberal than SSI, or (3) not deeming income at all when one spouse is institutionalized. The States no longer have the option of using more restrictive deeming criteria than SSI for these cases.

Under the SSI program, the statute requires that, if both an individual and his or her spouse apply or are eligible for SSI and cease to live together such as when one spouse is institutionalized, their income and resources must be considered to be mutually available, for the purpose of determining eligibility, for the first 6 months after the month they cease to live together (see 42 U.S.C. 1381a, 1382(a), and 1382c(b)). If only one spouse applies or is eligible for SSI, the SSI program must deem the income and resources of the other spouse only until the end of the month they cease to live together (42 U.S.C. 1382c(f)). For the eligible couple, their total income and resources are measured against the SSI standard for a couple; for couples where only one spouse applies or is eligible, the amount deemed is determined according to a set formula.

States that elect to provide Medicaid to all SSI beneficiaries must use SSI standards when determining Medicaid eligibility. However, States 1/ that elected, under section 1902(f), to use their 1972 Medicaid eligibility criteria could, under the old regulations, continue to deem as they did under their January 1, 1972, Medicaid plan. This meant that both the amount and duration of deeming could be more extensive than SSI standards, if authorized under the 1972

1/Connecticut, New Hampshire, New York, Virginia, Mississippi, North Carolina, Illinois, Indiana, Minnesota, Ohio, Oklahoma, Missouri, Nebraska, North Dakota, Utah, and Hawaii.

plan. For example, States could continue to deem for indefinite periods of time. Under the new rules, which were required by the decisions in the Gray Panthers case, 1902(f) States no longer are permitted to use any deeming criteria more extensive than SSI standards but may be more liberal if they wish.

The Gray Panthers case, as well as several others involving deeming, have been appealed to the Supreme Court. On June 25, 1981, the Supreme Court reversed the court of appeals and upheld the HHS pre-December 1980 deeming regulations in the 1902(f) States. The case was remanded to the lower court for consideration of any constitutional issues.

SUMMARY

The complexity of Medicaid's eligibility requirements makes State rules and practices in this area particularly vulnerable to challenges in the Federal courts. The fact that court decisions have not been consistent indicates that one State could adopt certain rules restricting eligibility but under comparable circumstances another State could be enjoined from enforcing the same or similar rules.

CHAPTER 5

STATE EXPERIENCES WITH COST SAVING INITIATIVES UNDER WAIVERS OF FEDERAL REQUIREMENTS

Currently, all States except Arizona participate in the Federal Medicaid program. Although States determine eligibility criteria, rates of payments, and benefits, they must do so within the Federal regulations and guidelines. This means that States must request Federal waivers of the regulations if they wish to institute certain cost-containment programs. Also, the Department's authority to waive certain Medicaid statutory requirements is mainly contained in section 1115 of the Social Security Act, which pertains specifically to demonstration projects. 1/

This chapter will discuss (1) some problems States have encountered with the waiver process and (2) examples of State attempts at reducing their costs for providing health care to the indigent population--with particular reference to Arizona.

PROBLEMS WITH WAIVER PROCESS

Using waivers as a means of increasing flexibility presents some concern to State officials. A major reason is the time required to process a waiver. According to a draft paper prepared by a staff member of the National Conference of State Legislators, processing a waiver request requires, on the average, over a year from initiation to final approval. In April 1981, the National Conference's State-Federal Assembly adopted a resolution suggesting that delaying cost-containment efforts until Federal waivers are granted is costly. A recent National Governors' Association report 2/ states that "[F]ederal approval of such waivers is anything but a certainty, and even if given, can be a lengthy process."

California's experience in requesting a waiver from several Federal regulations for its rural hospitals demonstrates how time consuming and frustrating the waiver process can be. 3/ In January 1979, State legislation became effective that allowed California's rural hospitals to diversify and provide long-term nursing home type care in hospital beds. This option of "swing-beds" was designed to

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1/The Department also has Medicaid waiver authority under sections 402 of the Social Security Amendments of 1967 and 222 of the Social Security Amendments of 1972. Unlike section 1115, these sections also permit waivers of certain Medicare provisions.

2/See page 5.

3/This information was obtained from a member of the Rural Health Division of California's Department of Health Services.

give small rural hospitals more flexibility in using surplus acute beds. A team of State employees worked on the waiver request part time over a period of about 4-1/2 months, submitting it to HCFA by June 1979.

The requested waivers involved Federal regulations setting out requirements for statewide uniformity, provider staffing requirements, reimbursement methods, and standards for SNFs and ICFs.

Because the proposed change would involve only rural hospitals, a waiver of 42 CFR 431.50, which requires consistent statewide implementation of the Medicaid program, was requested. Federal regulations also set staffing requirements for providing certain inpatient hospital services. Numerous waivers were requested to allow nurse practitioners, physician assistants, or experienced laboratory personnel with a master's degree to perform some of these functions. This involved 42 CFR 405.1021(h), 405.1024(b)(1) and (2), 405.1024 (g)(6), 405.1025(c)(1), 405.1026(h), 405.1028(d)(1), 405.1028(f)(2), 405.1029(d)(1), and 405.1031(d)(6). California also wished to change the normal methods of determining allowable costs for these rural hospitals. The State requested waivers of 42 CFR 405.402, 405.403, 405.404, 405.451, and 405.455(d). For providing long-term care in hospitals, California wanted exemption from some of the Medicaid conditions for SNFs and ICFs in 42 CFR 405.1101 Subpart K and 42 CFR 442.250 Subparts E and F. These primarily involved the requirements for support staff and physical facilities to provide rehabilitative services.

In December 1979, the State received notice that HCFA had denied the request but that the proposal should be revised and resubmitted with a more detailed and developed research methodology. Revised waiver requests were prepared by September 1980, but by January 1981, these too were denied. During this period, however, HCFA was working on legislation to allow swing-beds in rural hospitals. The concept had been tested in several other States. 1/ In December 1980, the Congress passed the Omnibus Reconciliation Act of 1980 which authorized swing-beds in rural hospitals of 50 or fewer beds, which may enable California to develop some of its diversification plans for rural hospitals. California is now awaiting Federal swing-bed regulations, which are anticipated by November 1981.

Another concern related to Federal waivers is the possibility of lawsuits. A HCFA official told us that both the length of time involved and the possibilities for litigation are valid concerns

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1/According to a HCFA official, Medicaid participated in "swing-bed" demonstration projects in Utah, South Dakota, and Texas. In these instances, the demonstration projects had already been set up under Medicare, and HCFA solicited the participation of the States. Therefore, a valid comparison between States' experiences in getting "swing-bed" waivers and California's cannot be made.

when considering the waiver process. This concern was also discussed in a draft memorandum prepared by the HHS staff. This memorandum, which discussed a strategy for implementing the Medicaid "cap," said that the waiver approach is not as definitive as legislative repeals of restrictive Medicaid provisions because waivers are "likely to result in extensive litigation." Although not involving waivers, California's and Alabama's experience (see ch. 3) demonstrates that, even if HHS approves a change in a State's plan, a court can rule that HHS reviewed the State's request incorrectly and, therefore, the approval is invalid.

STATE EXPERIENCES WITH COST-CONTAINMENT PROGRAMS NOT GENERALLY AUTHORIZED UNDER EXISTING FEDERAL REGULATIONS

Many States have instituted cost saving changes in their indigent health care programs. Most of the changes discussed below, except Arizona's, have required a Federal waiver.

Freedom of choice may limit cost containment

One of the Federal requirements that States consider most restrictive is "freedom of choice" for recipients. Section 1902 (a)23 of the Social Security Act provides that recipients may generally obtain services from any qualified Medicaid provider. An article in the "Western Journal of Medicine" states that the "mainstream ethos" of the Medicaid program "buys into the inefficiencies inherent in this country's health care system."

Arizona, because its indigent health care program is not funded under Medicaid, is not restricted by the "freedom of choice" requirement and therefore can designate which providers beneficiaries may use. Because it is a county funded and administered program, each county establishes its own health delivery system. In 1980, Cochise County contracted with physicians in various towns throughout the county to provide health care services to indigents. All participants in the county health program must use these physicians for primary care services. This change has enabled the county to negotiate a fixed rate per indigent and gain more control over costs. According to the director of the county's Department of Health Services, there have been few patient complaints with the new delivery system. Cochise County has also restricted the choice of drug providers. Rather than reimburse pharmacists, the county now purchases and dispenses its own drugs to most patients in the county health system. In 1979-80, the county paid pharmacies $263,436 for drugs. In the first 6 months of operation in fiscal year 1980-81, the county anticipates a savings of $30,000, even though there were initial capital outlay expenses for setting up the pharmacy. Savings of $150,000 over what would have been paid to private providers in 1981-82 are projected.

Maricopa County, Arizona, which includes Phoenix, has also limited recipients' freedom of choice of providers. That county provides all primary care, acute care, pharmacy, and laboratory services directly. The county funds and staffs nine primary care clinics throughout the county. The director of the Maricopa County Department of Health Services believes that, if he can control the primary care level, he has much better control over the rest of the health care system because that is the primary referral point for all services. The county also operates the county hospital, which provides all acute care for indigents in the county. The county provides the pharmaceutical and laboratory services for the primary care centers and the hospital.

Oregon does not have a medically needy program; however, Multnomah County has had a 5-year Federal demonstration grant to provide health care services to the medically needy not covered by Medicaid. During this period the county has served as a broker for enrolling beneficiaries into existing prepaid plans under a program called Project Health. Covered services include primary and acute care, laboratory and pharmacy services, eyeglasses, and home health care. To get the requested Federal waivers for Project Health, according to the project director, the county had to agree to allow any beneficiary who was dissatisfied with the prepaid plans to obtain care from physicians or hospitals under contract with the county on a fee-for-service basis. He said that few beneficiaries have used that option in the 5 years of the program.

The requested Federal waivers for the Multnomah project fall under seven categories: statewide operation, eligible provider organizations, controlled enrollment of beneficiaries, effective date of coverage, uniform services throughout the State, beneficiary cost sharing, and provider reimbursement systems. A waiver of 42 CFR 431.50 allowed Oregon to serve the medically needy in Multnomah County but not the entire State. Waiving 42 CFR 431.597 enabled Project Health and its subcontractors to contract for services even though some of the subcontractors may not have met this regulation's definition of a "health care projects grant center." Waiver of 42 CFR 435.906 was necessary because Project Health restricts enrollment to a geographical section of the State. Section 42 CFR 435.914 states that a Medicaid recipient could be eligible for benefits up to 90 days retroactively. Because Project Health has no provision for retroactive coverage in its contracts with the prepaid health plan, it requested this waiver. Project Health proposed allowing 365 days of hospital service coverage a year. Because the categorically needy Medicaid recipients in Oregon are limited to 21 days of hospital coverage a year, a waiver of 42 CFR 440.240 was considered necessary to allow this variation in statewide services.

Project Health beneficiaries may share in the cost of the prepaid plans and services depending on their family size and income, and the plan they selected. Because some of the enrollment fees and copayment levels exceed Medicaid limitations, waivers of 42 CFR 447.15, 447.52, and 447.54 were requested. Project Health covers some of its beneficiaries on a contracted fee-for-services basis. It uses prospective reimbursement rates which are not directly related to costs (for institutions) or prevailing charges (for outpatient services). Therefore, waivers of 42 CFR 447.261, 447.262, 447.273, 447.321, 447.331, and 447.341 were requested.

A portion (about 20 percent a year) of new Project Health beneficiaries are not covered by the prepaid plans because they are high-risk cases, largely composed of patients who enroll in Project Health after admission to a hospital. These people are handled on a fee-for-services basis until they can be enrolled into a prepaid plan. By putting these high-risk patients in a holding status, it is possible to cover most Project Health beneficiaries under prepaid contracts.

Beneficiaries who participate in the prepaid plans are given a choice among the prepaid plans with which the Project contracts. There are currently four plans, although at one time there were seven. If the beneficiary chooses the lowest cost prepaid plan, the premium for that plan is paid entirely by Project Health. If the beneficiary selects a higher cost plan, the beneficiary shares in the premium costs based on family size and income. A 1978 evaluation of Project Health conducted by an independent consulting firm concluded that, if a fee-for-service system was used for the entire medically needy population of Multnomah County, the costs would be 20 percent higher than the Project Health system. According to the consultant, there are differences between the medically needy and Medicaid cash grant beneficiaries which may reduce the 20 percent cost savings if Project Health was available to the general Medicaid population.

Reimbursement methods that can reduce costs

Federal regulations establish reimbursement methods for the various types of providers. A recent study by the National Governors' Association (see p. 5) states that these methods, based on reasonable costs or reasonable charges, share a common characteristic--they leave considerable control over the level of reimbursement and the rate of increase in reimbursement to individual providers or to providers as a group.

Physicians' fees

Medicaid regulations state that a physician's reimbursement cannot exceed the Medicare payment level for the physician for a given service. The Medicare physician reimbursement system is based upon a "profile" of charges system that develops maximum reimbursement levels specific to an individual physician for a given service (e.g., comprehensive office visit, electrocardiogram) 1/ as well as maximums for medical specialists and services by geographical areas within a State. 2/

California's Medicaid program has developed statewide maximums for each procedure. These are compared with the Medicare maximums for each procedure within the State's 28 Medicare designated geographical areas, but they are not compared against individual physicians' maximum Medicare rates (the so-called customary charges). In California's fiscal year 1980 Annual State Evaluation Report, HCFA Region IX cited California for not following Federal regulations by failing to make this comparison on an individual physician and procedure basis. Region IX began citing California for noncompliance in this area in its October 1, 1979, Quarterly Compliance Report. In April 1981, California responded that:

> "[Medicaid's statewide] maximums are nearly always considerably below Medicare's prevailing charge limitations [for a given geographic area]. It is true that in a small percentage of cases [Medicaid's] maximum allowance[s] may exceed the Medicare customary charge limitation for a specific provider for a given procedure. When this infrequent situation occurs, [Medicaid's] maximum will usually only exceed the Medicare maximum by a small amount * * *.
>
> "To require the State to overlay its reimbursement system with the complicated and costly Medicare profile system does not seem to be a feasible and practical alternative * * *."

According to a HCFA Region IX official, the region may amend its compliance report on California.

Hospitals

Medicaid regulations require that States reimburse hospitals based on "reasonable cost." Generally, this means that States use

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1/Often referred to as the doctor's "customary charge" under Medicare.

2/Referred to as the "prevailing charge."

Medicare principles, unless the State has approval from the Secretary of HHS to utilize a different payment system. A common criticism of Medicare's system of reimbursing hospitals is that it is based on costs and is determined retrospectively. Therefore, higher costs mean higher reimbursement; lower costs mean lower reimbursement. As a result, many health analysts believe such a system provides little incentive for efficiency.

California's attempt to obtain and implement a plan to restrict increases in hospital reimbursement has taken 5 years (see ch. 3).

New Jersey has received a waiver from HCFA that allows Medicaid to participate in a new hospital reimbursement system. The New Jersey Department of Health has developed a system for reimbursing hospitals based on the various diagnoses of patients within the hospital, or the "case mix." Under this experimental system, many of the State's hospitals are paid a fixed amount based on the average costs incurred in treating patients with a particular diagnosis, rather than for the number of services provided or the number of days which a patient resides in the hospital. In addition, a hospital which holds its costs below the allowable rate retains the savings which it achieves. Under State law, the State can also bring private and commercial coverage (e.g., Blue Cross) patients under this Diagnostic Related Groups Experiment.

Long-term care

Another area covered by Medicaid regulation is long-term care. In a 1979 report, 1/ we stated that:

> "Medicaid's eligibility policies and benefit package creates a financial incentive to care for the chronically impaired elderly in nursing homes because:
>
> --Medicaid, Medicare and other public programs provide little or no financial coverage for long-term care services in the community;
>
> --Medicaid, at the same time, offers full or partial coverage for long-term care in nursing home."

New York, however, has a waiver from HCFA which permits Medicaid reimbursement for services not normally reimbursed when provided at home. This experiment is known as "Nursing Home Without Walls." Home care is being used as a voluntary alternative to

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1/"Entering a Nursing Home--Costly Implications for Medicaid and the Elderly" (PAD-80-12, Nov. 26, 1979).

institutionalization for Medicaid patients. To be eligible, a patient must meet the medical criteria for placement in either SNFs or ICFs. Maximum reimbursement is set at 75 percent of the going rate in a locale for the SNF or ICF level of care for which the client is certified. As of August 31, 1980, the average monthly budget for each patient was $785, compared to $1,351 for long-term institutional care and $6,600 for acute hospital care.

SUMMARY

Current Medicaid requirements require States to seek waivers to implement a variety of cost saving changes but usually in connection with an experiment or demonstration project. Obtaining waivers is not always assured or timely. Nevertheless, a number of States are attempting to demonstrate that they can better contain costs by deviating from various Federal requirements for the Medicaid program.

COURT CASE CITATIONS

Case reference and date	CCH reference
CHAPTER 2	
PRIOR INDIVIDUAL NOTICE AND RIGHT TO HEARING BEFORE REDUCTION OR TERMINATION OF BENEFITS	
Alice Silvey, et al. v. Emmett Roberts, Secretary of Florida Department of Health and Rehabilitative Services, et al. U.S. District Court, Middle District of Florida, Jacksonville Division (8/3/73)	26,767
Regina Jennings v. Neil Solomon, Secretary Maryland Department of Health. U.S. District Court, District of Maryland (11/7/76); U.S. Court of Appeals, Fourth Circuit (6/5/79)	28,105 29,742
Sarah Feld v. Stephen Berger. U.S. District Court, Southern District of New York (12/28/76)	28,099
William Yanetsky, et al. v. Carmen Shang, et al., U.S. District Court, Southern District of New York (1/10/78) (10/17/79); U.S. Court of Appeals, Second Circuit (8/25/80)	28,744 30,418 30,656
Mary K. Turner, et al. v. James F. Walsh. U.S. District Court, Western Division of Missouri (7/25/77)	28,735
Washington Nursing Center, Inc., et al. v. Quern. U.S. District Court, Southern District of Illinois, Southern Division (11/18/77)	28,976
Ellen Stenson v. Barbara Blum. U.S. District Court, Southern District of New York (9/18/79)	30,014
Philadelphia Welfare Rights Organization v. Helen O'Bannon. U.S. District Court, Eastern District of Pennsylvania (10/15/79)	30,158

APPENDIX I

Case reference and date	CCH reference
MEDICAL CARE ADVISORY COMMITTEES	
Judy A. Robinson, et al. v. Edward W. Maher, Commissioner of Social Services, et al. U.S. District Court, District of Connecticut (1/19/76)	27,707
Idabelle Benton and William Wisebaker v. James A. Rhodes. U.S. District Court, Southern District of Ohio, Eastern Division (5/11/76); U.S. Court of Appeals, Sixth Circuit (8/10/78)	28,025 29,191
Itha D. Becker, et al. v. Toia, Commissioner, et al. U.S. District Court, Southern District of New York (6/27/77) (12/28/78)	29,525 29,521
Roger Addison, et al. v. W. B. Holliday, et al. U.S. District Court, Northern District of Mississippi, Greenville Division (10/5/78)	29,407
Janice Dunn v. Leon H. Ginsberg, Commissioner. U.S. District Court, Southern District of West Virginia (7/23/80)	30,802
Rossier Jennings, et al. v. Lamar Alexander, et al. U.S. District Court, Middle District of Tennessee, Northeastern Division (9/3/80)	30,735
PENNSYLVANIA'S COVERAGE OF EYEGLASSES	
Ralph White v. Frank S. Beal. U.S. District Court, Eastern District of Pennsylvania (4/21/76); U.S. Court of Appeals, Third Circuit (5/5/77)	27,808 28,438
Budnicki, et al. v. Beal, et al. U.S. District Court, Eastern District of Pennsylvania (5/25/78)	29,115
Charles Eder v. Frank S. Beal. U.S. Court of Appeals for the Third Circuit (11/14/79); U.S. District Court, Eastern District of Pennsylvania (5/20/80)	30,072 30,513
Dexter H. Simpson v. David Wilson. U.S. District Court, District of Vermont (10/26/79)	30,108

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Case reference and date	CCH reference
Margarette Curtis v. William J. Page, Jr. U.S. District Court, Northern District of Florida, Tallahassee Division (4/18/79); U.S. Court of Appeals, Fifth Circuit (9/11/80)	29,649 30,661
FREEDOM OF CHOICE OF PROVIDERS	
Bay Ridge Diagnostic Laboratory, Inc. v. Dumpson. U.S. District Court, Eastern District of New York (8/14/75)	27,482
CHAPTER 3	
HOSPITAL REIMBURSEMENT ISSUES	
Wisconsin Hospital Association v. Wilbur J. Schmidt, Secretary of Wisconsin Department of Health and Human Services. U.S. District Court, Eastern District of Wisconsin (12/29/75) (4/28/76)	27,620 27,818
California Hospital Association v. Mario Obledo, State Health and Welfare Secretary. U.S. District Court, Central District of California (7/16/76); U.S. Court of Appeals, Ninth Circuit (8/27/79)	27,998 29,970
Illinois Hospital Association, et al. v. Dan Walker, Governor of Illinois, et al. U.S. District Court, Northern District of Illinois, Eastern Division (3/25/77)	28,371
Hospital Association of New York, Inc., v. Philip L. Toia, Commissioner. U.S. District Court, Southern District of New York (7/30/76) (9/28/76) (11/9/76) (2/14/77) (8/5/77) (10/14/77) (4/25/79)	27,941 28,026 28,058 28,304 28,588 28,655 29,671
NURSING HOME REIMBURSEMENT ISSUES	
Alabama Nursing Home Association, et al. v. Califano, Jr., et al. U.S. District Court, Middle District of Alabama, Northern Division (7/12/77) (12/23/79); U.S. Court of Appeals, Fifth Circuit (5/7/80)	28,542 29,578 30,504

Case reference and date	CCH reference
Golden Isles Convalescent Center, Inc., d/b/a Hallandale Rehabilitation Center v. Califano. U.S. District Court, Southern District of Florida (10/18/77)	28,710
Florida Nursing Home Association, et al. v. Page, et al., Golden Isle Convalescent Center, et al. v. Page, et al. U.S. Court of Appeals, Fifth Circuit (5/16/80)	30,502
Florida Department of Health and Rehabilitative Services, et al. v. Florida Nursing Home Association, et al. U.S. Supreme Court (3/2/81)	30,913
Illinois Health Care Association v. Quern. U.S. District Court, Northern District of Illinois, Eastern Division (12/14/77)	28,711
Nebraska Health Care Association, Inc. v. Exon. U.S. District Court, District of Nebraska (12/18/77)	28,712
Wisconsin Association of Homes for Aging v. Carballo. U.S. District Court, Eastern District of Wisconsin (12/1/77)	28,713
CHAPTER 4	
DISPUTES PERTAINING TO STATES' ADMINISTRATION OF THE "SPEND-DOWN"	
Marion Aitchison, et al. v. Stephen Berger, et al. U.S. District Court, Southern District of New York (11/12/75)	27,566
Greklek v. Toia. U.S. Court of Appeals, Second Circuit (11/28/77)	28,695
Caroline Winter v. Quern. U.S. District Court, Northern District of Illinois (4/9/80)	30,572
Webb v. Aggrey. U.S. District Court, Northern District of Ohio	28,362
Jennie Thom, et al. v. Aggrey. U.S. District Court, Northern District of Ohio (6/29/77)	29,420

Case reference and date	CCH reference
TRANSFER OF ASSETS	
Mary Buckner, et al. v. Edward Maher, Commissioner of Social Services of Connecticut. U.S. District Court, District of Connecticut (12/1/76)	28,359
Julia Fabula v. Buck. U.S. Court of Appeals, Fourth Circuit (5/21/79)	29,688
Ethel Caldwell v. Blum. U.S. District Court, Northern District of New York (11/29/79) (11/4/80); U.S. Court of Appeals, Second Circuit (4/16/80); U.S. Supreme Court (5/6/80)	30,093 30,774 30,453 30,500
Rossye Dawson v. Myers. U.S. Court of Appeals, Ninth Circuit (5/14/80)	30,501
DEEMING OF INCOME	
Elizabeth Brown v. Wayne Stanton. U.S. Court of Appeals, Seventh Circuit (1/30/80)	30,171
Dorothy Bohl v. Harris. U.S. District Court, Southern District of Ohio, Western Division (11/8/79)	30,098
John Foard, et al. v. Gibson. U.S. District Court, Western District of North Carolina, Charlotte Division (3/27/79)	29,679
Jack Ruben v. Creasy. U.S. District Court, Southern District of Ohio, Western Division (4/13/79)	26,678
Krygier v. Buscaglia. U.S. District Court, Western District of New York (5/2/79)	29,761
Nonnie Mae Norman v. St. Clair. U.S. District Court, Southern District of Mississippi (4/26/79); U.S. Court of Appeals, Fifth Circuit (1/28/80)	29,677 30,302
Gray Panthers v. Secretary, HEW. U.S. District Court, District of Columbia (12/8/78); U.S. Court of Appeals, District of Columbia	29,426 30,588

Case reference and date	CCH reference
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Allen v. Califano. U.S. District Court, District of Utah (8/23/79)	-
Manfred v. Maher. U.S. District Court, District of Connecticut. (9/13/77)	28,629
M. W. and J. Burns v. R. W. Vowell, Commissioner, Department of Public Welfare. U.S. District Court, Southern District of Texas, Houston Division (8/30/76)	28,072
Ruth Griswold v. William Page, HRS Secretary. U.S. District Court, Northern District of Florida, Tallahassee Division (5/20/77)	28,537
Hanke v. Nyhus. U.S. District Court, District of Minnesota, Fourth Division (5/29/79)	29,760
Alan Franson v. Andera Juros, Administrator of the Public Welfare Division, and Jacob Tanzer, Director of the Department of Human Resources. U.S. District Court, District of Oregon (5/5/75)	27,536

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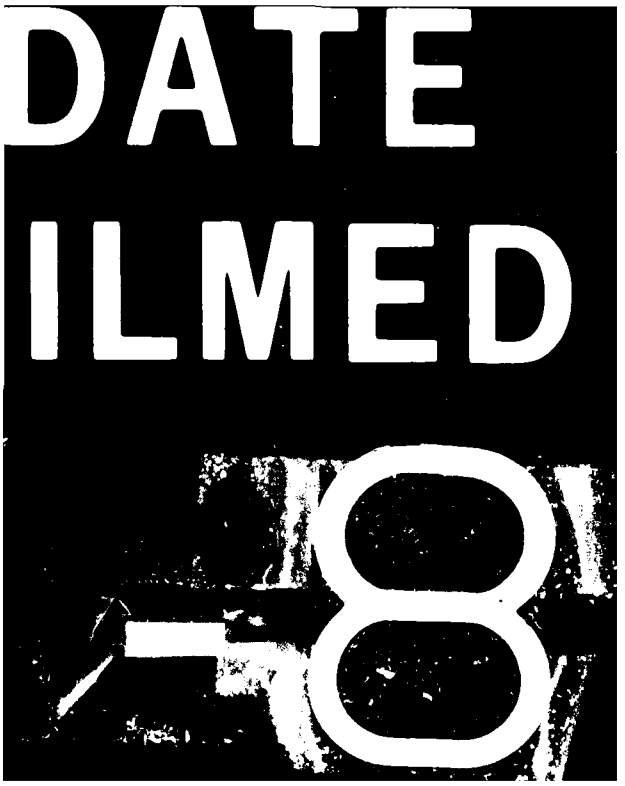
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